

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-036074

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

5232

FILED OCT 9 1963

VS 300
Rev. 4/59

1
23x282
3
4 1
5 0
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7 0
8 1
9 773.5
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12 56-2
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Win J. Legg

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City, Missouri</u>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Conley Maternity Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Route #29</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLEN KAY DALRING</u>		4. DATE OF DEATH Month Day Year <u>September 6, 1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <u>New Born</u>	8. DATE OF BIRTH <u>9/4/63</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) Months <u>2</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>
11a. FATHER'S NAME <u>Edward Joseph Dalsing</u>		11b. MOTHER'S MAIDEN NAME <u>Orletha Mary Sausser</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		12b. SOCIAL SECURITY NO.	
13a. NAME OF HUSBAND OR WIFE <u>Orletha Dalsing Rt. #29 Kansas City, Missouri</u>		13b. ADDRESS	
14. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Respiratory Distress Syndrome</u> DUE TO (b) <u>Hyaline Membranous Disease</u> DUE TO (c) <u>Premature</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Kansas City, Missouri</u>
21. I attended the deceased from <u>9/4/63</u> to <u>9/6/63</u> and last saw her alive on <u>9/6/63</u> . Death occurred at <u>11:31</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Win J. Legg</u> (Degree or title) <u>MD</u>	
22b. ADDRESS <u>7220 No. 48th St. Trufey KC 18, Mo.</u>		22c. DATE SIGNED <u>9/19/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <u>Conley Hosp. K. C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-16-63</u>	26. REGISTRAR'S SIGNATURE <u>Beattie Smith</u>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.
If this body is not embalmed, fact should be so stated above.